Please print or type **Date Issued:** _____

FACILITY COMPLAINT FORM

Name of Nurse: _____
First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (___) _____ Work Phone #: (___) _____

Nurse's License #: _____ Nurse's SS #: _____

Nurse's Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone #: (___) _____ Contact Person: _____

Facility Name (if different than employer): _____

Facility Type: (Hospital, Staffing Agency, LTC/Nursing Home, Clinic, etc.)

Facility Address: _____

City: _____ State: _____ Zip: _____

Facility Phone #: (___) _____

Your Name: _____
First Middle Last

Position: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (___) _____ Daytime Phone #: (___) _____

Please write a description in as much detail as possible, stating the exact nature of your complaint(s) against this nurse. (Use as many additional sheets as necessary, number them and sign each one at the bottom.)

List the name, address, and telephone number of any witnesses to the occurrence(s), including any person who was present at the time of the occurrence(s).

Name	Address	Telephone #s (Work/Home)	Still Employed at your Facility?

What is the current status of the nurse's employment with your facility? _____

_____

Have you filed this complaint with any other person or organization? ☐ Yes ☐ No

If so, with whom? _____

_____

The Board is not permitted to release any information about an investigation until a final order is issued. If you wish to be notified of the Board's decision in this case, please check below.

☐ Yes, I wish to be notified of the Board's decision.